MENTAL HEALTH PATIENT ADVOCATE OFFICE

1990 ANNUAL REPORT

Alberta HEALTH

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Alberta

HEALTH
Mental Health Patient
Advocate Office

12th Floor, Centre West Bldg., 10035 - 108 Street, Edmonton, Alberta, Canada T5J 3E1 403/422-1812

February 11, 1991

The Honourable Nancy J. Betkowski
Minister of Health
323 Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Madam Minister:

It is my pleasure to present the First Annual Report of the Mental Health Patient Advocate Office in accordance with **Section 47(1)** of the **Mental Health Act.**

Annual reports characteristically comprise rather terse, matter-of-fact presentations of yearly activities, and often contain minimal narrative commentary. Considerable interest in this new office, however, has been generated by many principal players in the mental health field. It thus seems important to provide a somewhat expanded overview for this initial year of operation. The present report consequently includes a procedural outline of office operations as well as additional introductory sections by way of narrative commentary. It is anticipated that this detailed coverage of functional and philosophical aspects can be largely excluded from subsequent annual submissions – hopefully in favour of additional case summary information precluded from the present report.

This inaugural report covers primarily the period from January 1 to December 31, 1990.

Respectfully submitted,

M.W. Hislop, PhD, CHE
Mental Health Patient Advocate

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Mental Health Patient Advocate Office

With the proclamation of Alberta's new **Mental Health Act** on January 1, 1990, the Lieutenant Governor in Council appointed the first statutorily mandated Mental Health Patient Advocate in Canada to assist psychiatric patients in understanding and exercising their rights. The office also has authority to investigate concerns relating to formal (certified or committed) clientele involuntarily detained in mental health facilities designated under the Act and Regulations.

Alberta has adopted a leadership role in this regard. While psychiatric advocacy services have been offered in at least one other Canadian jurisdiction (Ontario) for over seven years, that system functions somewhat differently in both philosophy and practice, and establishment of the Advocate's office in Ontario has not been enshrined in a legislative base. Other provinces have not as yet seen fit to create a dedicated advocacy service for psychiatric patients, even in the context of recently revised mental health statutes which reflect recommendations promulgated in 1987 by the Uniform Law Conference of Canada's model legislation. The latter document, which witnessed the collaborative input of seven provincial jurisdictions including Alberta, provided strong support as well as explicit operational recommendations for a dedicated psychiatric "patient advisor service to confer with, advise and assist involuntary patients" (**Uniform Mental Health Act**: Section 20(1-4)).

Introductory Remarks

The very term 'advocacy' connotes numerous interpretations. Dictionary definitions quote such synonyms as defending, recommending, pleading for or generally aiding the cause of by approving, favouring and supporting. There is no quarrel with those terms, but we would add to that roster the requirements of informing and clarifying – cardinal considerations in regards to rights-related issues. Common parlance connotes other interpretations of the term as well, some of which cast a mould into which both the philosophy and operations of the Alberta service find an uncomfortable fit. Certainly, this office does not fastidiously focus on lobbying for its constituency in quite the same sense that characterizes certain consumer advocacy movements. While fostering and supporting systemic change in psychiatric services do represent paramount priorities, it would be fallacious to infer from this that the office's principal *raison d'etre* is to provide a convenient conveyance for implementing the concerns of vested interest lobby groups in the mental health arena.

Perhaps the concept which captures both the philosophy and function of this office best is that of an 'ombudsman'. Intrinsic to this term is the notion of a balanced sense of fairness in rendering judgements on issues wherein authoritative actions are seen to fail in striking an

appropriate balance between apparently conflicting rights of individuals, agencies and society at large. Indeed, it would appear that one predominant rationale for creating this dedicated advocacy service for formal psychiatric patients is recognition that the locus for mental health service delivery is becoming rapidly removed from one or two large, centralized inpatient facilities and extending into the community hospital sector where provincial ombudsmen do not characteristically carry jurisdiction. In addition, there is growing acknowledgement of both the highly specialized needs and unique 'legal space' of involuntarily committed psychiatric patients, who represent the sole segment of our society which has historically been deprived of fundamental freedoms sans the trappings of due process accorded other citizens – including those in our criminal justice system.

Responsible advocacy for mental patients, or any other segment of society, should support and encourage utilization of the various mechanisms set up by social agencies, institutional facilities and government in general for redressing individual concerns. Thus, this office often refers complainants back to appropriate authorities instead of actively intervening in initial instances – particularly when callers indicate they have neglected to present their problems to appropriate internal personnel for possible redress. To act otherwise conveys a message that the hands-on advocacy so imperative on the part of front-line care givers is neither noted, appreciated, nor expected on an ongoing basis. When interacting with principal players in the mental health arena, this office takes great care to disavow any notions of supplanting this day-to-day consumer-focused caring which comprises the foremost form of advocacy activity that can continuously and consistently 'make a difference' in any pervasive sense of the term.

At present, the Patient Advocate's mandate is quite limited, and the office is seeking a broadening of its official purview in any subsequent amendments to the **Mental Health Act**. While few restrictions pertain to the range of complainants who can approach the office on behalf of current or former formal patients, or to the nature of issues that can be pursued on the basis of complaints pertaining to these persons, investigations are relatively restricted on two major fronts. One limitation is the general inability to initiate own motion investigations in the absence of a complaint; these are confined to the committal process and to the procedures for informing formal patients and their guardians, relatives or designates of rights provisions under the Act. More serious, perhaps, is the strictured scope to focus exclusively on current or former formal patients, and the inherent inability to pursue even complaint-based concerns relating to informal patients or those detained in designated mental health facilities under remands, compulsory care orders, Lieutenant Governor warrants or even single admission certificates under the **Mental Health Act**. The gaps created by this narrow mandate are exacerbated by the fact that many of these same patient groups were previously accorded ready recourse to the Provincial Ombudsman before such jurisdiction for psychiatric inpatients was removed by the proclamation of Bill 29 and concomitant creation of this office.

These mandate limitations have also introduced day-to-day difficulties in assessing jurisdictionality in instances when events of focal concern have occurred in the past and where clients have had repeated previous admissions as formal patients. Such complications have resulted in legal as well as interpretive problems, and continue to confound the most significant single challenge confronting this office – that of establishing effective access for its prescribed clientele. The nature of our operation prescribes the maintenance of a 'central headquarters' workforce in order to be responsive to incoming calls. So doing, however, minimizes the office's ability to provide the on-site contact often necessary for patients who are confused, frightened, angry, reluctant or otherwise unable to initiate either telephone or written contact with us on their own initiative. It has thus seemed important that the office enhance its accessibility for such patients through periodic routine visits to designated facilities across the province as time and staffing permit. Despite generally good cooperation from most facilities with respect to such on-site initiatives, existing mandate restrictions have resulted in considerable confusion which has in turn occasionally thwarted these attempts at proactive patient access, and further impeded the office's ability to establish an effective overall 'presence' in the eyes of the very clientele that this statutorily created service is intended to serve.

Recommendations have been made to address these and other issues relating to the office's legislative base. One of these proposes a broadening of the office's prescribed purview to include all psychiatric in-patients residing in facilities which are designated under the Act. It is invariably awkward for any office to advocate on its own behalf with respect to augmenting its statutory authority without appearing parochial or self serving. In this instance, the objective is simply to establish a rationally viable mandate for office operations that is consonant with both past practices and the protective provisions previously accorded all psychiatric inpatients in designated mental health facilities.

No such remedies are required, however, in response to other publicly expressed concerns regarding the reporting relationship of the Patient Advocate to the Minister of Health. One could scarcely wish for a more meaningful locus of accountability than to the senior elected official responsible for health care in the province – one who is in turn mandated

to account for this office directly to the Provincial Legislature. It provides for the Patient Advocate office being sufficiently intimate with the system to influence changes from within, while at the same time maintaining an arms-length relationship independent of the bureaucracies it is intended, in part, to monitor. Unless immaculate independence is sought as an end in itself, a more effective mechanism for public accountability would appear difficult to come by.

The Mental Health Patient Advocate Office

The Alberta **Mental Health Act** (Bill 29), provides for the appointment of a Mental Health Patient Advocate to assist patients in designated psychiatric facilities in understanding and exercising their rights, and to investigate concerns or complaints relating to patients committed and involuntarily detained under the Act. The Patient Advocate office is centrally located in downtown Edmonton, and comprises of a staff of four: The Mental Health Patient Advocate, Assistant Patient Advocate, Patient Advocate Representative and a clerical/ administrative support person. This small staffing complement, coupled with a province-wide mandate, prescribe that considerable office activity must transpire via telephone, correspondence or 'fax' machine. Visits to designated facilities do occur on a periodic basis, however – both proactively and in response to individual or collective complaints.

Functional Overview

Current or former psychiatric patients, or anyone on their behalf, may submit enquiries or complaints regarding any person who is or has been a formal patient. Formal patients are persons who are involuntarily detained in designated psychiatric facilities under either two admission certificates or two renewal certificates as prescribed in the **Mental Health Act.** To date, thirteen hospitals throughout the province have been designated as psychiatric facilities able to admit formal patients. If it is uncertain whether the person who is the subject of a concern has been formally certified under the Act, the Patient Advocate office may be contacted directly and will ascertain the legal status of the patient. Telephone enquiries may be made to the Edmonton office at **422-1812**; calls from locations outside the Edmonton area may be placed free of long-distance charges through local Alberta Government RITE operators.

Written complaints should preferably contain as much detailed information as possible, be marked 'confidential' and mailed directly to:

Office of the Mental Health Patient Advocate
12th Floor, Centre West Building
10035 - 108 Street
Edmonton, Alberta
T5J 3E1.

Formal patients can have a wide range of questions or concerns about which they may approach the office of the Patient Advocate. These include general rights provisions, certification concerns, care and treatment matters, or day-to-day issues involving social and/or financial problems. There

are no limits to the kinds or numbers of complaints that can be made to the Patient Advocate office so long as any issues raised relate to a period during which the person who is the subject of concern had formal patient status.

When the Patient Advocate office receives an enquiry or complaint, information is provided, where appropriate, about:

- the rights of formal patients under the **Mental Health Act**;
- how formal patients may obtain legal counsel;
- how applications to a Review Panel are made;
- how appeals to the Court of Queen's Bench may be commenced through the assistance of legal counsel.

Responses to enquiries are attended to with alacrity, commencing on a same-day basis wherever feasible. The Patient Advocate office initially reviews any issues presented in order to ensure that it has the authority to pursue them. If the Patient Advocate does not have jurisdiction, this fact is explicitly acknowledged. Depending on the issue, the office may be able to make general enquiries for information relating to the matter, but can do so only by way of informal assistance and not in any 'official' capacity. Most non-jurisdictional issues are simply referred to the most appropriate source that has authority to deal with the problem. In this regard, the Patient Advocate has established and maintains open, reciprocal communications with other offices offering mechanisms for redressing public concerns (e.g., the Provincial Ombudsman, RCMP Public Complaints Commission, Children's Advocate, Health Facilities Review Committee, Human Rights Commission, etc.).

If the issue at hand is jurisdictional, a decision is made as to whether the concerns raised require a formal investigation. Wherever possible, the office attempts to resolve matters informally, without introducing officious investigative protocols; formal investigations are not normally required in order to address most concerns presented on behalf of formal patients. Rather, resolution is most often attained through simply closing communication gaps, straightening 'kinks' in the communication process, or by negotiating a patient's position with appropriate officials at the facility or agency in question.

Where allegations are of an extremely sensitive nature or serious accusations are made against specifically-named individuals, formal investigative procedures will usually be necessary. In these instances, the Patient Advocate is required to provide written notification to any patient who is the subject of an investigation, the board of the facility or facilities in question, and any other persons named in the complaint. An investigator is assigned to review relevant clinical and administrative records, along with any other documents or information relating to issues raised in the complaint. This investigator will make all enquiries considered necessary to conduct the investigation, and the office may engage the services of lawyers, psychiatrists or other persons to assist in the investigation as required.

The Patient Advocate office does not require a complaint in order to initiate an enquiry or investigation into:

- any procedure of a facility relating to the admission of persons detained in a facility under the **Mental Health Act**; or
- any procedure of a facility for informing formal patients of their rights, or for providing information as required by the **Mental Health Act** to guardians, nearest relatives or designates of formal patients.

When an enquiry or investigation is completed, the Patient Advocate office advises the patient and other principal parties as appropriate regarding disposition of the matter. In the case of formal investigations, this must be provided in writing, and the facility in which the patient is or was detained will also receive a summary report which may include either case specific or general systemic recommendations relating to the issues investigated. All enquiries and investigations are conducted in strict confidence, and the Patient Advocate office will not disclose information pertaining to any aspect of case activity except as required by law or by the performance of its duties under the **Mental Health Act**.

Activity Summary: Proactive Development and Resource Contacts

During this inaugural year of operation, extensive activity has been directed toward 'proactive development' of the office in addition to case work per se. Initiatives have been undertaken to actively interface with most principal players currently or previously impacting the mental health arena – offices of the Provincial Ombudsman, Public Trustee, Public Guardian, Human Rights Commission, Children's Advocate, senior officials in numerous government departments, and Chairpersons of various review/steering committees. Other major stakeholders contacted include executive and front-line staff of numerous service agencies, legal associations, consumer organisations and self-help groups (both provincial and regional chapters). All designated psychiatric facilities have been contacted and, with the exception of two not currently accepting formal patients, all have received on-site visits – many on multiple occasions to meet with board officials and various administrative or clinical personnel. In excess of 220 site visits, meetings and telephone conferences – all in addition to case related contacts – have been conducted; several of these transpired during the last few weeks of 1989. Over 60 of these events have involved detailed discussions, articles or interviews relating to the office, 34 of which constituted formal presentations. Numerous other contacts reflect 'resource' services to agencies and designated facilities seeking assistance with systemic issues involving formal psychiatric patients. An abbreviated listing of these collective agency, facility and media contacts may be found in the Appendices.

A number of our proactive endeavours have entailed, for want of a more suitable term, active 'lobbying' on behalf of mental health clientele. These latter advocacy activities have included recommendations to the Minister of Health regarding the constituent make-up of provincial and regional mental health advisory committees; correspondence with police detachments vis-a-vis policy development pertaining to the apprehension, detention and conveyance of psychiatric patients; meetings with the Public Guardian office in relation to interface issues between mental health and other protective provisions for dependent adults; conferences with the Legal Aid Society regarding representation on treatment issues and the extension of duty counsel services for formal patients; and communications with numerous facility boards regarding a variety of policies and procedures relating to psychiatric inpatients.

In response to questions and concerns from several designated hospitals, the office also prepared a 'Patient Rights Summary' suitable for posting in units

accommodating formal patients. A copy of this poster may be found in the Appendices. In addition, arrangements have been made with the Department of the Attorney General regarding automatic notifications to this office of any scheduled fatality inquiries resulting from deaths of formal patients in psychiatric facilities; such inquiries are routinely attended by a representative from the Patient Advocate office.

Finally, the office has made recommendations regarding a number of issues pertaining to interpretations and applications of the new **Mental Health Act**. It is axiomatic that many new pieces of legislation, particularly protective statutes reflecting strong social sensitivities, inevitably experience 'teething problems' during the initial stages of enactment. The Patient Advocate office is in a unique position to detect difficulties with respect to mental health legislation from a patient perspective, and this has resulted in a substantial number of suggested amendments to the **Mental Health Act** and its pursuant **Regulations** being presented to the Department of Health for review and appropriate action.

Activity Summary: Case Work

The Patient Advocate office's legislated mandate and hence principal focus is on psychiatric inpatients who are or have been certified and involuntarily detained under the **Mental Health Act**. Annual admissions figures under the new Act are not yet available, but it appears there are approximately 250 such formally committed patients in designated psychiatric facilities across the province at any given time. Actual numbers range from about 215 to 280 during the course of the year, and are checked quarterly by this office. The 250 average comprises 12.5 per cent of the approximately 2,000 total psychiatric inpatient population of the province, and represents about 17 per cent of those 1,500 psychiatric inpatients residing in the thirteen hospitals designated under the Act. A listing of these designated facilities may be found in the Appendices.

The range of issues brought to our attention has run the gamut from complaints concerning apprehension and detention to accusations of alleged abuse. Items involving personal possessions, hospital privileges, administrative policies and social/financial matters are occasionally cited problem areas, but by far the most common concerns have centred around involuntary detention and treatment for formal patients. We are committed to the perspective that the primary nature of our business is one of assisting patients to resolve their concerns, and not simply one of conducting officious investigations into perceived psychiatric transgressions. It is thus gratifying that, except for a single sensitive complaint involving alleged abuse, it has proved both possible and effective to address issues informally, without need for enforcing the official investigative protocols provided in the Patient Advocate Regulation. Generally, our enquiries in response to patients' concerns have met with willing, courteous and complete cooperation from the respective facilities involved.

In pursuing patient concerns, the office has adopted a fundamental operating tenet that there is no such thing as a 'trivial' complaint. While it is essential to ultimately screen out frivolous or vexatious concerns we acknowledge that, in the eyes of the complainant, problems presented rarely seem picayune or immaterial. Yet it may appear to the casual observer that many of the issues dealt with in our day-to-day activities seem less than earth-shaking in importance. There is a cardinal consideration to be borne in mind here: what is important to someone who has the freedom of choice to come and go at will, and what is important to an individual whose activities are almost entirely regimented by the facility in which he or she is unwillingly compelled to reside, can be worlds apart. It is imperative that patients regard this office as a voice that will speak on their behalf; hopefully, this

perception in itself may ease in some small measure the strain of involuntary hospitalization. On the other hand, if it becomes necessary to inform clients that their allegations cannot be substantiated, or that the institutional authority was justified in its actions, it is also hoped there may be more willing acceptance of this information from the Patient Advocate's staff simply because of their acknowledged independence from the detaining facility.

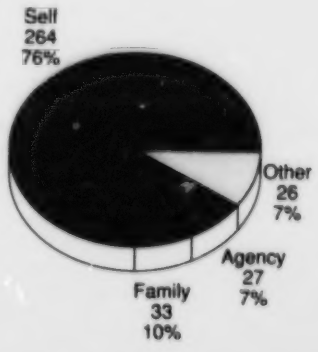
Our degree of involvement by way of interceding on behalf of patients is a judgment call based on numerous factors, the most salient of which are jurisdictionality and clients' apparent ability to intervene on their own behalf. We hold firm the view that the essence of effective advocacy is helping patients to help themselves, but such perspectives prescribe some initiative on the complainant's part in contacting appropriate authorities offering possible redress for consumers in the psychiatric service system. Hence, the office exercises judgment in determining when to actively intercede on clients' behalf as opposed to simply assisting them by way of information, guidance and support in pursuing problem resolution on their own. Of course, some patients are unable to initiate or pursue action on their own behalf, and the legislation appropriately provides for this office to act on the basis of a third party referral in these instances. The information provided must be sufficiently specific and detailed to do so, however; the office can intercede neither responsibly nor effectively by presuming to act on anonymous or imprecise information concerning the complainant and circumstances in question.

An issue of some sensitivity has entailed occasional perceptions by a few facility personnel that the office 'takes sides' in supporting patients during the course of enquiry or investigative activity. There is a crucial difference, however, between 'blindly believing' patients with respect to their allegations, and simply regarding them as sufficiently credible to warrant pursuit of their concerns. It is incumbent on this office to 'go that extra mile' in relation to issues raised by patients who are seen, on occasion quite validly, as perhaps delusional or as chronic complainers. Despite the best of intentions, legitimate concerns of such individuals can often be given short shrift because of a 'cry wolf' history of previously unsubstantiated accusations or claims. Extra effort on our part in responding to these complainants comprises an essential element of this office's *raison d'etre*, unless patients' complaints are sufficiently bizarre as to unequivocally preclude rational pursuit. In short, this office must give complainants the benefit of the doubt – without prejudging or taking sides – in all but exceptional circumstances when initiating enquiries in response to their concerns. But such seriousness of intent in pursuing patients' problems must not be mistakenly confused with the prejudgment of investigative outcomes.

There have been few available data bases for accurately forecasting case activity levels of this new office. Overall figures for this initial year of operation seem somewhat higher than anticipated, however – reflecting a total of 350 initial case contacts or files opened, and entailing in turn 775 independent issues. Recidivist requests, those from complainants continuously contacting the office on a daily or weekly basis, have not been redundantly counted in arriving at these figures. In all, 1,691 case related contacts – either personal, written or telephone – were engaged in during the course of dealing with clients over the year. This last figure does not include any internal case conferences, meetings related to office operations, or 'caucus' sessions dealing with more systemic issues that case activity can collectively generate. The following figures and tables depict various breakdowns of case activity; where required, these are accompanied by appropriate definitions and interpretive comments.

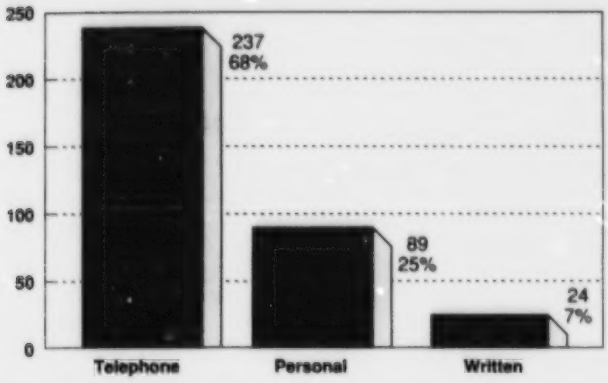
Figures I and II denote respectively the sources and manner of initial client related contacts for files opened during the year. **Figure I** provides a breakdown of initial case contacts, showing the numbers and proportions involving patients themselves, family members or agencies on their behalf, or other alternative sources (friends, facility staff, other patients, etc.). **Figure II** simply provides information pertaining to the mode or 'format' of these initial contacts. These figures do not differentiate between office initiated contacts and those service requests originating from clients themselves or from third party referrals. Office initiated contacts derive from our periodic pre-arranged visits to designated facilities. These on-site endeavours increased in frequency during the final quarter of the year; they account for a relatively small portion of the 'self' sources of contact depicted in **Figure I,** and for most of the 'personal' contacts reflected in **Figure II**.

FIGURE I
Sources of Initial Case Contact



Total number of Files = 350

FIGURE II
Modes of Initial Case Contact



Total number of Files = 350

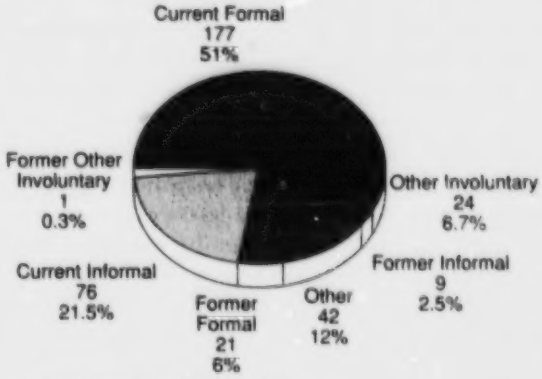
In future reports, it may be possible to present data pertaining to the relative numbers of files opened for various designated facilities across the province. 'Raw' data in the form of absolute numbers, however, would be both meaningless and misleading because of the large variances in admission rates for formal patients among facilities. Such data would require presentation as a proportion of formal admissions to each respective facility in order to accurately reflect relative service request rates, and such statistics are not available for the 1990 calendar year at the time of writing.

Figure III illustrates a breakdown of legal status for subjects of call in case activity during the year. The term subject of call refers to patients for whom files have been opened and not necessarily to the 'callers' or referral sources involved, though these individuals are in most instances one and the same. The phrase 'other involuntary' in this figure denotes patients detained in designated psychiatric facilities under remands, Lieutenant Governor warrants, compulsory care orders, or single admission certificates under the **Mental Health Act**. The term 'other' represents a 'catch-all' category for subjects of call not falling into any of the other classifications; for the most part, it reflects persons not currently in hospital and for whom previous admissions histories are unknown.

Figure IV shows a breakdown of the major types of issues addressed over the year. The categories chosen would not seem to demand additional definition, and are of necessity approximate since many issues may be classified in more than one way, depending on the relative emphasis involved.

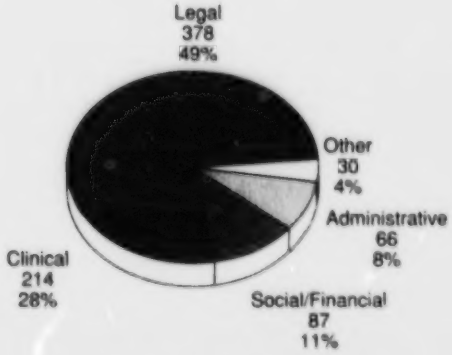
Table I speaks to the disposition of issues addressed during the year – illustrating outcomes independently for jurisdictional as opposed to non-jurisdictional matters. Of the

FIGURE III
Subjects of Call



Total number of Files = 350

FIGURE IV
Issues



Total number of Issues = 775

775 issues presented to the office, only 513 or 66 per cent were jurisdictional. The term 'resolved' here does not necessarily denote complete consumer satisfaction, but rather reflects tangible actions and outcomes which capture all that could reasonably be expected or accomplished by this office relative to the issue at hand. A formal patient calling to be released from a designated facility where he/she is being involuntarily detained is an appropriate (and common) example. This office could inform and instruct such a patient in procuring, completing and forwarding an appropriate application to the review panel; assist in arranging legal representation for a panel hearing or for pursuing a more immediate *habeas corpus* action; provide general guidance pertaining to a subsequent Court of Queen's Bench appeal; and offer detailed rights-related information and/or assistance regarding various aspects of custody and care in the facility. All viable services, perhaps, but scarcely sufficient to yield complete client satisfaction in virtually

every instance. Other categories of disposition would seem to be adequately defined in the 'Legend' without need for additional elaboration.

Finally, the number of personal, written or telephone case related contacts engaged in during the course of dealing with clients over the year is 1,691. The range of contacts per case runs from one or two to about 100 (in very exceptional circumstances), producing an overall mean of almost five contacts per file. Of course, many complainants present more than one matter for assistance or investigation, so this average is very approximate. Numbers of contacts for non-jurisdictional issues tend to be characteristically lower, since these matters are most often handled by simple information provision or are 'declined and referred' to other avenues of redress.

TABLE I
Issues - Disposition

	Jurisdictional	Non-Jurisdictional	Total	
			#	%
R	304	80	384	50
U	67	13	80	10
D	60	22	82	10
D&R	54	130	184	24
NR/NA	27	16	43	5.5
NR/RNF	1	1	2	0.5
Total Issues	513	262	775	100

LEGEND:

R - **Resolved**
(fully or partially; see previous note);

U - **Unsubstantiated**
(verification not obtained, or issue remains sufficiently undefined as to preclude pursuit);

D - **Discontinued**
(enquiries/investigation dropped by the office or patient due to lack of ability/need to further pursue; this can include an inability to establish jurisdictionality);

D&R - **Declined and Referred**
(pertains primarily to non-jurisdictional cases when information or informal assistance are inappropriate or insufficient to resolve the matter; for jurisdictional cases, denotes either that the patient is capable of pursuing remedy via established mechanisms but has made no attempt to do so, or that ultimate resolution is beyond the scope of office authority);

NR/NA - **Not Resolved**
(remedy not available);

NR/RNF - **Not Resolved**
(recommendations not acted upon, or investigation/follow-up not yet completed).

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Appendices

Proactive Development and Resource Contacts

Government Departments and Agencies:

Alberta Attorney General

- Civil Law Division
- Crimes Compensation Board
- Family Court Services
- Public Trustee

Alberta Family and Social Services

- Children's Advocate
- Deputy Minister
- Income Support Services
- Public Guardian
- Regional Offices

Alberta Health

- Finance and Administration
- Health Facilities Review Committee
- Interdepartmental Committee on Mental Health
- Legal Services Division
- Mental Health Division
- Minister and Deputy Minister
- Policy and Planning Division
- Review Panel Chairpersons

Alberta Labour

- Human Rights Commission

Provincial Ombudsman

Facilities:

- Alberta Hospital Edmonton
- Alberta Hospital Ponoka
- Calgary General Hospital
- Canadian Forces Hospital, Cold Lake
- Foothills Hospital, Calgary
- Fort McMurray Regional Hospital
- Grey Nuns Hospital, Edmonton
- Holy Cross Hospital, Calgary
- Leduc General Hospital
- Lethbridge Regional Hospital
- Medicine Hat Regional Hospital
- Misericordia Hospital, Edmonton
- Queen Elizabeth II General Hospital, Grande Prairie
- Royal Alexandra Hospital, Edmonton
- University of Alberta Hospital, Edmonton

Community Agencies and Organizations:

- Advocacy Centre for the Elderly, Toronto, Ontario
- Alberta Mental Health Nurses Interest Groups
- Calgary Association of Self Help
- Canadian Bar Association
- Canadian Mental Health Association
- Citizens Commission on Human Rights
- Edmonton Home Care Services
- Edmonton Police Department
- Independent Living Society, Grande Prairie
- Legal Aid Society of Alberta
- Lethbridge Family Services Association
- Psychiatric Hospitals Social Workers Forum
- Regional Day Centre Society, Edmonton
- Registered Psychiatric Nurses Association of Alberta
- Royal Canadian Mounted Police
- Schizophrenia Society of Alberta

Articles/Interviews/Conferences/ Media Contacts:

- Alberta Hospital Association (Article)
- Alberta Hospital Edmonton (Newsletter Interview)
- Alberta Law Foundation: Health Law Institute (Article)
- Canadian Mental Health Association (Newsletter Interview)
- CKIC Radio, Calgary (Interview)
- CKNW Radio, Vancouver, B.C. (Interview)
- Community Connections, Edmonton
- Edmonton Journal (Interviews and Information Contacts)
- Edmonton Sun (Interview)
- Emergency Psychiatry and Crisis Response Conference, Edmonton (Panel Presentation)
- Globe and Mail, Toronto, Ontario (Interview)

YOUR RIGHTS UNDER THE MENTAL HEALTH ACT

Alberta
HEALTH
Mental Health Patient
Advocate Office

IF YOU ARE A **FORMAL (INVOLUNTARY) PATIENT UNDER THE MENTAL HEALTH ACT** YOU HAVE NUMEROUS RIGHTS. THE MENTAL HEALTH PATIENT ADVOCATE OFFICE HAS SUMMARIZED A FEW OF THESE RIGHTS FOR YOUR INFORMATION.

RIGHTS REGARDING YOUR DETENTION

YOU HAVE THE RIGHT to be informed of the reasons for your involuntary detention, and to receive copies of your admission or renewal certificates.

YOU HAVE THE RIGHT to appeal being kept in hospital against your will by applying to the Review Panel.

> The hospital will provide you with the name and address of the Review Panel Chairman, an application for review (Form 12), and any assistance you may require in making your application to the Review Panel.

YOU and your lawyer HAVE THE RIGHT to be present when evidence is given at the Review Panel hearing, and to question any person who gives evidence.

YOU HAVE THE RIGHT to appeal a decision of the Review Panel to not cancel your admission or renewal certificates.

RIGHTS REGARDING YOUR TREATMENT

YOU HAVE THE RIGHT to refuse a treatment if you are mentally competent to make your own treatment decisions.

> If you object to treatment, your doctor may apply to the Review Panel. The Review Panel will review your situation, and either support your objection or support your doctor's application for a compulsory treatment order.

YOU HAVE THE RIGHT to apply to the Review Panel for a hearing to appeal your doctor's certificate stating that you are not mentally competent to make your own treatment decisions.

YOU and your lawyer HAVE THE RIGHT to be present when evidence is given at Review Panel hearings, and to question any person who gives evidence.

YOU HAVE THE RIGHT to appeal a treatment order or other written decision of the Review Panel.

GENERAL RIGHTS

YOU HAVE THE RIGHT to contact and receive visits from your lawyer at any time.

> You may arrange legal representation for your Review Panel hearing if you so desire. Appeals of Review Panel decisions are made to the Court of Queen's Bench, and will require the assistance of a lawyer.

YOU HAVE THE RIGHT to confidentiality for all clinical records pertaining to your care in hospital, and for any communications written by you or to you. Hospital staff cannot open, read, withhold or interfere with the delivery of your correspondence.

YOU HAVE THE RIGHT to receive visitors during visiting hours fixed by the hospital unless your doctor thinks that visitors would be harmful to your health.

YOU HAVE THE RIGHT to contact the Office of the Mental Health Patient Advocate regarding any questions or concerns that you might have with respect to your rights or care while in hospital.

FOR ADDITIONAL INFORMATION CALL:

THE MENTAL HEALTH PATIENT ADVOCATE OFFICE AT:
- EDMONTON: 422-1812
- OTHER CENTRES IN ALBERTA:
  CALL LOCAL RITE OPERATOR – ASK FOR 422-1812
  (NO LONG DISTANCE CHARGES APPLY)

Mental Health Regulation

Designation of facilities

2(1) The following places are designated as facilities for the care, observation, examination, assessment, treatment, detention and control of persons suffering from mental disorder:

- **a** The Alberta Hospital Edmonton;
- **b** The Alberta Hospital Ponoka;
- **c** The Calgary General Hospital – Bow Valley Centre;
- **d** Canadian Forces Hospital Cold Lake;
- **e** The Foothills Provincial General Hospital, Calgary;
- **f** The Holy Cross Hospital, Calgary;
- **g** Misericordia Hospital, Edmonton;
- **h** Royal Alexandra Hospital, Edmonton;
- **i** University of Alberta Hospital, Edmonton;
- **j** Grey Nuns Hospital, Edmonton;
- **k** Lethbridge Regional Hospital;
- **l** Medicine Hat Regional Hospital;
- **m** Fort McMurray Regional Hospital.

(2) The Forensic Services Unit of The Calgary General Hospital and The Alberta Hospital Edmonton are designated as facilities for the purposes of section 13 of the Act.

Mental Health Act

Part 6
Mental Health Patient Advocate

Definition

44 In this Part, "Patient Advocate" means the Mental Health Patient Advocate appointed under section 45.

Patient Advocate

45(1) The Lieutenant Governor in Council shall appoint a Mental Health Patient Advocate, who shall investigate complaints from or relating to formal patients and exercise such other powers and perform such other duties as are prescribed in the regulations.

(2) The Lieutenant Governor in Council may make regulations

(a) respecting the powers and duties of the Patient Advocate;

b) requiring boards to make available any information referred to in the regulations for the purpose of an investigation by the Patient Advocate.

Employees and advisors

46(1) In accordance with the *Public Service Act* there may be appointed any employees required to assist the Patient Advocate in performing his duties under this Act.

(2) The Patient Advocate may engage the services of lawyers, psychiatrists or other persons having special knowledge in connection with his duties under this Act.

Annual report

47(1) As soon as possible after the end of each year, the Patient Advocate shall prepare and submit to the Minister a report summarizing his activities in that year.

(2) On receiving a report under subsection (1), the Minister shall lay a copy of the report before the Legislative Assembly if it is then sitting, and if not, within 15 days after the commencement of the next ensuing sitting.

Order In Council

APPROVED AND ORDERED,

W. HELEN HUNLEY,

Lieutenant Governor,

o.c. 716/89

December 14, 1989

Edmonton, Alberta

Upon the recommendation of the Honourable the Minister of Health, the Lieutenant Governor in Council, pursuant to section 45(2) of the Mental Health Act, SA 1988 cM-13.1, makes the regulation in the attached Appendix, being the Patient Advocate Regulation.

DON R. GETTY
Chairman

Patient Advocate Regulation

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Definitions

1 In this Regulation,

(a) "Act" means the Mental Health Act;

(b) "formal patient" includes a person who has been a formal patient;

(c) "Patient Advocate" means the Mental Health Patient Advocate appointed under the Act.

Delegation

2 The Patient Advocate may in writing delegate to any person holding any office under him any power or duty conferred or imposed on him under the Act or the regulations under the Act, except the power of delegation in this section and the power or duty to make any report under the Act or regulations.

Power to act on a complaint relating to a formal patient

3(1) On receipt of a complaint from or relating to a formal patient, the Patient Advocate

(a) shall notify the board of the facility in which the formal patient is detained of the nature of the complaint,

(b) shall notify the formal patient, in writing, that a complaint has been received, of the nature of the complaint and of any investigation arising from the complaint,

(c) if a person other than a formal patient is named in the complaint, shall notify that person of any investigation arising from the complaint, and

(d) shall make any contact with the formal patient and conduct any investigation of the complaint that the Patient Advocate considers necessary.

(2) If a complaint relates to a formal patient who has been transferred from one facility to another, the notice for subsection (1)(a) shall be provided to the boards of both facilities.

(3) A formal patient and a person who has received notice of an investigation under subsection (1)(c) has the right to make representations to the Patient Advocate relating to the complaint.

(4) The Patient Advocate may investigate a complaint only as it relates to the period during which the person who is the subject of the complaint was subject to 2 admission certificates or 2 renewal certificates.

(5) On receipt of a complaint, the Patient Advocate shall provide to the formal patient and to the complainant, as far as is reasonable, information respecting the following:

(a) the rights of the formal patient under the *Mental Health Act;*

(b) how the formal patient may obtain legal counsel;

(c) how to make an application to the review panel;

(d) how to commence an appeal to the Court of Queen's Bench.

Power to initiate an investigation without a complaint

4 The Patient Advocate may, without receiving a complaint, initiate and conduct an investigation into

(a) any procedure of a facility relating to the admission of a person detained in a facility pursuant to the Act, and

(b) any procedure of a facility

(i) for informing a formal patient of his rights, or

(ii) for providing information as required by the Act to guardians, nearest relatives or designates of a formal patient.

Procedures

5(1) The Patient Advocate

(a) shall maintain a record relating to every complaint and every investigation under this Regulation, and

(b) may make any inquiries he considers necessary to conduct an investigation.

(2) The Patient Advocate shall notify the board of a facility of his intention to contact a patient or a formal patient of the facility and the board shall grant the Patient Advocate access at all reasonable times.

(3) The Patient Advocate shall notify the board of a facility of his intention to carry out an investigation that relates to the facility, whether the investigation arises pursuant to section 3 or 4.

(4) The Patient Advocate is not required to hold a hearing.

(5) If the Patient Advocate requests in writing from the board of a facility

(a) any policy or directive of the facility,

(b) any medical or other record or any information, file or other document relating to a patient or a formal patient who is the subject of an investigation under section 3 or 4, or

(c) any other information, file or document relating to an investigation under section 3 or 4,

the board shall, within a reasonable time after receipt of the request, provide access to the materials requested.

(6) If the Patient Advocate so requests, the board shall provide a copy of any materials requested under subsection (5).

Disclosure

6 The Patient Advocate shall not disclose information obtained in the course of an investigation except as required by law or in the performance of his duties under the Act or this Regulation.

Report

7(1) On completion of an investigation, the Patient Advocate shall prepare and send to a board a copy of the report of the investigation.

(2) A report that contains recommendations shall state the reasons for the recommendations.

(3) If a report is sent to a board under subsection (1) and within a reasonable time after the report is sent to the board the Patient Advocate is of the opinion that the board has not taken appropriate action on any recommendation, the Patient Advocate shall send a copy of the report and the board's response, if any, to the Minister.

Frivolous complaint

8 The Patient Advocate may refuse to investigate or cease to investigate a complaint if in his opinion

(a) the subject matter of the complaint is trivial,

(b) the complaint is frivolous or vexatious, or

(c) having regard to all of the circumstances, no investigation is necessary.

Notice to complainant

9 The Patient Advocate

(a) shall inform a formal patient of the disposition of any complaint that relates to the formal patient, and

(b) may inform a complainant of the disposition of any complaint initiated by the complainant

Coming into force

10 *This Regulation comes into force on January 1, 1990.*